

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

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1400 E. Washington Avenue
Madison, WI 53703

E-Mail: web@drl.state.wi.us
Website: <http://www.drl.state.wi.us>

CERTIFICATE OF POSTGRADUATE TRAINING

MEDICAL EXAMINING BOARD

(Not necessary if utilizing FCVS)

IMPORTANT: PLEASE FORWARD THIS FORM TO YOUR POSTGRADUATE TRAINING PROGRAMS (This form may be photocopied)

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: _____

HOSPITAL NAME: _____

HOSPITAL ADDRESS: _____

HOSPITAL TELEPHONE: _____

1. In what type and level(s) of training did this physician participate at your facility? Check each level in which physician participated, provide starting and ending dates of his/her training in your program and type of training and whether credit was given for the training.

DATES (MO/YR)	SPECIALTY	CREDIT	NO CREDIT	PARTIAL CREDIT
_____ PGY 1 _____				
_____ PGY 2 _____				
_____ PGY 3 _____				
_____ PGY 4 _____				
_____ FELLOWSHIP _____				
_____ OTHER _____				

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 2. Was the residency/fellowship accredited by ACGME of the AMA or AOA? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Did the physician complete the full training program in good standing?
If no, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Was the physician asked to or required to repeat any portion of the training at your facility?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |

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	<u>YES</u>	<u>NO</u>
5. Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility? If yes, please attach explanation on a separate sheet.	<input type="checkbox"/>	<input type="checkbox"/>
6. Was this physician recommended for the Board Certification examination in this specialty?	<input type="checkbox"/>	<input type="checkbox"/>
7. Was this physician granted a leave of absence while training at your facility? If yes, please attach explanation on a separate sheet.	<input type="checkbox"/>	<input type="checkbox"/>
8. Did this individual have a record of unexcused absences during his/her attendance at this training program?	<input type="checkbox"/>	<input type="checkbox"/>
9. Were any restrictions and/or special requirements placed on this physician's activities that were not placed on all other residents/fellows at his/her level of training? If yes, please attach explanation on a separate sheet.	<input type="checkbox"/>	<input type="checkbox"/>
10. Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet.	<input type="checkbox"/>	<input type="checkbox"/>
11. Were any incident reports filed involving the professional behavior or conduct of this physician? If yes, please attach explanation on a separate sheet.	<input type="checkbox"/>	<input type="checkbox"/>
12. Was this physician ever subject to non-routine monitoring while at your facility? If yes, please attach explanation on a separate sheet.	<input type="checkbox"/>	<input type="checkbox"/>
13. Were any malpractice actions filed naming this physician as a defendant that involved his/her period of training at your facility? If yes, please attach explanation on a separate sheet.	<input type="checkbox"/>	<input type="checkbox"/>
14. Is there any additional information in this physician's file that would assist the Board in determining this applicant's eligibility for licensure. If yes, please attach explanation on a separate sheet.	<input type="checkbox"/>	<input type="checkbox"/>

Print name of Program Director _____

Signature of Program Director _____

Date form was completed _____

**SEAL OF
HOSPITAL**

(If hospital does not have a seal,
a letter attesting to this fact, on
hospital stationery, must
accompany this certificate)

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935